STERLING chiropractic & wellness

CONFIDENTIAL
Health History Form
Chiropractic

778-484-6123
309 Bank Road
Kelowna, B.C.
V1X 6Y4

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

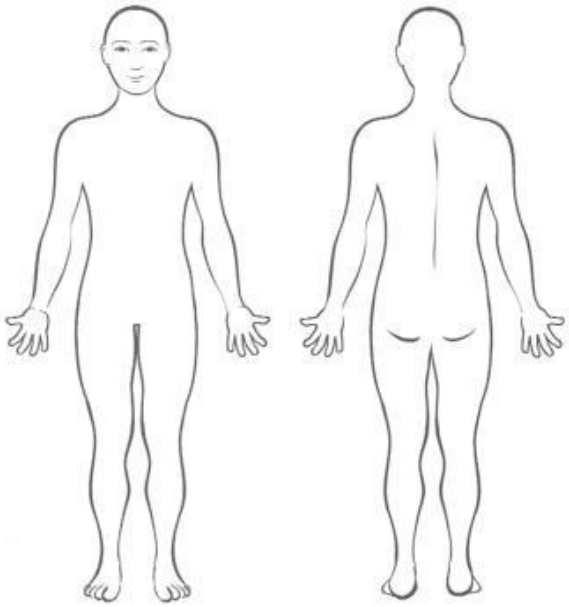
Name: _____ Phone #: Home_____Cell_____
Address: _____ Postal Code: _____
Occupation: _____ Employer: _____ Care Card #: _____
Marital Status: _____ Number of Children: _____ Gender: M☐F☐ Age: _____
Medical Doctor: _____ Phone: _____ Last Visit: _____
Reason for Visit: _____ Testing? _____ Results?: _____
Do you have extended health benefits? Y☐N☐ Company:_____ Policy #: _____
If you would like to be contacted by email, please provide it here: _____
Please check which number you prefer to be contacted by during daytime hours: Home☐ Cell☐
How would you like to be contacted for appointments? Email☐ Text☐ Phone☐ If text, what carrier are you with?_____
How did you hear about us?: _____
Date of Birth: _____
Permission to contact your medical doctor: *SIGN* _____

Emergency Contact: _____ Phone #: _____

**MAJOR HEALTH CONCERN THAT BRINGS YOU HERE:** _____
First started: _____
Was it a work related incident? Y☐N☐ If yes, was it reported to WCB? Y☐N☐ Claim #: _____
Was it related to an auto incident? Y☐N☐ If yes, what is your ICBC claim #: _____
Is this an RCMP, DVA, etc. claim? Y☐N☐ If yes, what is your claim #: _____

**HEALTH HISTORY**

Reason for this visit: _____
Have you had this condition previously? Y☐N☐ If so, when?: _____
What makes this issue better?: _____ Worse?: _____
How would you rate your pain out of 10?: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
What type of pain?: Throbbing☐ Piercing☐ Intermittent☐ Constant☐ Ache☐
Please indicate on the drawing exactly where the pain is occurring:



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Any surgeries/accidents/illnesses?: _____Dates:_____
Are you taking any: Painkillers ☐ Muscle Relaxants ☐ Medication ☐ Supplements ☐
If yes to any of the above, what medications are you currently taking? _____
What are the medications for?: _____

Please check any conditions are applicable:

| | | |
|---|---|---|
| ☐ muscle spasms | ☐ aneurysm | ☐ bone disease |
| ☐ numbness or tingling in hands/feet | ☐ stroke | ☐ high/low blood pressure |
| ☐ any recent falls | ☐ heart condition | ☐ cancer |
| ☐ whiplash | ☐ osteoporosis | ☐ digestive issues |
| ☐ head injury or concussion | ☐ diabetes | ☐ menstrual issues |
| ☐ dizziness | ☐ arthritis | ☐ asthma |
| ☐ headaches | ☐ pregnancy | ☐ anxiety/stress |
| ☐ depression | ☐ neurological issues | ☐ other: _____ |

**LIFESTYLE**

Height: _____ Weight: _____ Hours of sleep per night: _____ Quality of sleep: _____
Hours of sleep in a row: _____
Do you smoke? Y ☐ N ☐ Exercise: Daily ☐ Weekly ☐ Other ☐
Do you drink coffee? Y ☐ N ☐ How many cups per day?: _____
Do you drink alcohol? Y ☐ N ☐ How much?: _____
Stress Level: High ☐ Moderate ☐ Low ☐ Very Little ☐
Do you meditate? Y ☐ N ☐

Have you seen a chiropractor before? Y ☐ N ☐ When?: _____
Were you happy with the care you received?: Y ☐ N ☐
What condition were you seeing a chiropractor for? _____

**OTHER THERAPIES AVAILABLE**

Please check any other therapies you are interested in that we offer. The doctor may suggest some to support your healing and recovery:

| | | |
|---|---|---|
| ☐ Laser | ☐ Matrix Repatterning | ☐ Massage Therapy |
| ☐ Spinal Decompression | ☐ Nutrition Analysis | ☐ Craniosacral Therapy |
| ☐ Shockwave Therapy | ☐ Medi Mudding | ☐ Quantum Reflex Analysis |

Please Note:

Your appointment time is reserved especially for you. Please allow 24 hours for cancellation. Payment is due upon receipt of treatment, whether private or insured.

I authorize Sterling Chiropractic & Wellness to collect my information and communicate with other health professionals if needed. I understand my medical and personal information is confidential and will not be disclosed without my permission.

I give permission to be contacted prior to my appointment as a reminder: *INITIAL* _____

I give consent to be treated by the R.M.T's at Sterling Chiropractic & Wellness: *INITIAL* _____

I give Sterling Chiropractic & Wellness permission to use my email to remind me of appointments and provide wellness information: Y ☐ N ☐

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**Informed Consent to Chiropractic Treatment**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic.

In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms of muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been know to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is already a stroke in progress. However, you are being informed of this reported association because a stroke may cause a serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.
d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by the chiropractor including any recommended spinal and extremity adjustments.
I intend this consent to apply to all of my present and future chiropractic care.

Date: _____

_____ _____
Patient Signature (legal guardian) Signature of Witness

_____ _____
Please print name Please print name